

Investigations.—A.E.G. showed slight enlargement of the ventricle on the left side. EEG: Left side very much more abnormal than right, with focus in left temporo-parietal region.

The differential diagnosis lies between lesions of the basal ganglia which have been described as causing this picture and bilateral cortical lesions in the lower part of the motor cortex, producing what is, in effect, a pseudo-bulbar palsy. In view of the mild right hemiparesis and slight enlargement of the left lateral ventricle, this was thought to be the more likely. The lesion presumably was more severe on the left side.

Unusual Case of Symptomatic Migraine.—GRAHAME WILSON, M.D. (for DENIS WILLIAMS, M.D., F.R.C.P.).

W. J., female, aged 19.

Her father and grandfather had suffered from migraine. The patient had a normal birth and her childhood development was normal. Since aged 3 years she had suffered from atypical migrainous headaches recurring at intervals of approximately six weeks, although at times the intervals were longer, and once two years elapsed between attacks.

These were heralded by nausea and vomiting which occurred after she had retired to bed for the night. This did not interfere with sleep but on awakening next day she always had a dull frontal headache, more pronounced over the left side. During the next twelve hours the headache gradually radiated over her head to the occiput, then disappeared. During this time she was nauseated and photophobic and preferred to lie in a darkened room. The attacks were often brought on by excitement or exposure to bright sunlight.

On 30.8.55 she went to bed as usual, awoke after half an hour feeling sick and vomited several times during the night. Next day she complained of dull frontal headache, nausea and mild giddiness. Several hours later the headache became much more severe and she again vomited. She then retired to bed but can remember little of the next two to three days, during which time she was confused and consistently complained of aching pain in her neck and left arm and leg. She was noted to have a weakness of the left external rectus muscle and examination of the cerebrospinal fluid showed xanthochromic staining.

When she regained full consciousness she had no complaints other than diplopia, the result of the left external rectus weakness, which slowly improved. She had no further attacks of headache.



FIG. 1.—Plain X-rays of skull.

On examination.—Normal-looking girl of average intelligence; right-handed, and with no speech defect. The limbs were of normal development. There was slight left external rectus palsy and an equivocal right extensor plantar response.

X-ray of skull.—In the left parieto-occipital region and extending deeply towards the mid-line lay irregular flecks of calcification scattered over a wide area. The skull vault was asymmetrical, the left side being flattened in the lateral but slightly deeper in the vertical diameter. The skull sutures showed mild diastasis but the dorsum sellæ appeared to be normal (Fig. 1).

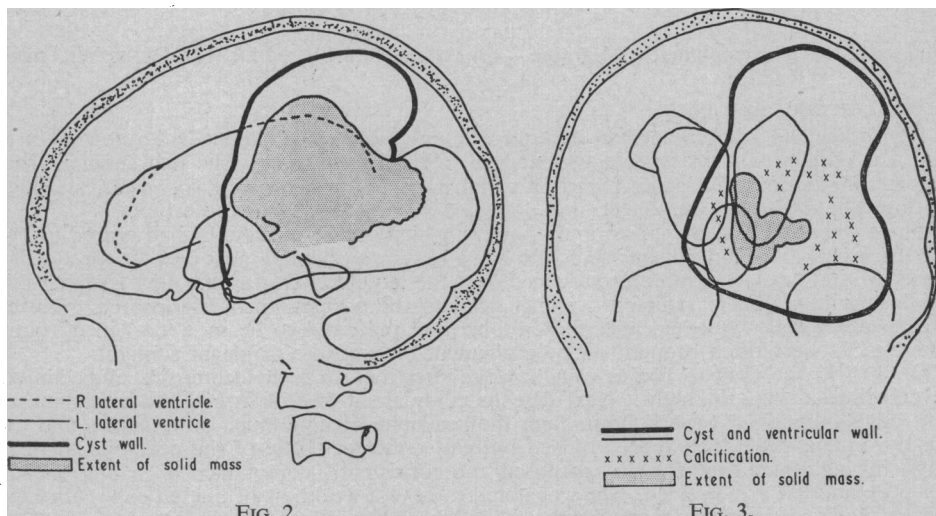
Electroencephalogram.—The alpha rhythm of 10 c/sec. was disturbed by frequent runs of high voltage delta waves in both occipital areas. Elsewhere the records were disturbed by slow and fast activity, with the addition of a focal abnormality in the left temporal region, consisting of irregular low voltage $2\frac{1}{2}$ –3 c/sec. waves.

Left carotid angiogram.—The left sylvian group of vessels were stretched and splayed out over the whole of their course, suggesting the presence of a hydrocephalus.

Ventriculogram.—Symmetrical dilatation of the anterior ends of both lateral ventricles, and although the septum pellucidum lay vertically it was situated 0.5 cm. to the right of

the mid-line due to the asymmetry of the skull. The third ventricle lay centrally but was dilated; the fourth ventricle was normal in size and position. In the left posterior parietal region lay a large porencephalic cyst in free communication with the lateral ventricle. Lying within the latter was a shadow cast by a large neoplasm which extended beyond the mid-line and roughly overlay the area of irregular calcification seen in the plain X-rays of the skull (Figs. 2 and 3).

Blood Wassermann negative.



FIGS. 2 and 3.—Composite tracing of postero-anterior and lateral views of ventriculogram films.

Dr. Denis Williams thought the patient's attacks were due to an intermittent hydrocephalus produced by the benign tumour lying in the lateral ventricle. It was obvious that it had been present for many years and on first thoughts he questioned the advisability of surgical exploration as there was a definite risk of producing a permanent hemiplegia and aphasia. However, in view of her age and the probability of further attacks with deterioration in her condition he felt she would have to be explored.

Mr. K. W. E. Paine suggested that the tumour was a choroid-plexus papilloma.

Subsequent exploration by **Mr. Wylie McKissock** through a left parietal osteoplastic flap revealed a huge choroid-plexus papilloma which occupied most of the left lateral ventricle. During removal troublesome hæmorrhage was encountered from vessels at its base. Thereafter the patient was right hemiplegic and aphasic and died seven days later.

[*This Meeting will be continued*]